DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/23/2012 FORM APPROVED OMB NO. 0938-0391

NT OF DEFICIENCIES I OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G553	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	CO	ATE SURVEY MPLETED /05/2012
		1921 5	4TH AVE W	DDE	
NORTHWEST INL	DIANA INC, THE	MERR	ILLVILLE, IN 46410		
(EACH DEFICIE	NCY MUST BE PERCEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHO	OULD BE	(X5) COMPLETION DATE
		W0000			
Dates of survey March 5, 2012	: February 27, 28, 29 and				
Provider number	er: 15G553				
1 -	-				
state findings in 9. Quality Review co	n accordance with 460 IAC empleted 3/14/12 by Ruth				
	PROVIDER OR SUPPLIE NORTHWEST INI SUMMARY (EACH DEFICIE REGULATORY O This visit was for recertification a Dates of survey March 5, 2012 Facility number Provider number AIM number: 1 Surveyor: Chri Surveyor III/QM The following of state findings in 9. Quality Review con	PROVIDER OR SUPPLIER NORTHWEST INDIANA INC, THE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) This visit was for a fundamental recertification and state licensure survey. Dates of survey: February 27, 28, 29 and March 5, 2012 Facility number: 001067 Provider number: 15G553 AIM number: 100245460 Surveyor: Christine Colon, Medical Surveyor III/QMRP The following deficiencies also reflect state findings in accordance with 460 IAC	PROVIDER OR SUPPLIER PROVIDER OR SUPPLIER NORTHWEST INDIANA INC, THE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) This visit was for a fundamental recertification and state licensure survey. Dates of survey: February 27, 28, 29 and March 5, 2012 Facility number: 001067 Provider number: 15G553 AIM number: 100245460 Surveyor: Christine Colon, Medical Surveyor III/QMRP The following deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 3/14/12 by Ruth	PROVIDER OR SUPPLIER PROVIDER OR SUPPLIER NORTHWEST INDIANA INC, THE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) This visit was for a fundamental recertification and state licensure survey. Dates of survey: February 27, 28, 29 and March 5, 2012 Facility number: 001067 Provider number: 15G553 AIM number: 100245460 Surveyor: Christine Colon, Medical Surveyor III/QMRP The following deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 3/14/12 by Ruth	OF CORRECTION IDENTIFICATION NUMBER: 15G553 A. BUILDING 9.00 03. WING PROVIDER OR SUPPLIER NORTHWEST INDIANA INC, THE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) This visit was for a fundamental recertification and state licensure survey. Dates of survey: February 27, 28, 29 and March 5, 2012 Facility number: 001067 Provider number: 15G553 AIM number: 100245460 Surveyor: Christine Colon, Medical Surveyor III/QMRP The following deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 3/14/12 by Ruth

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

001067

(X6) DATE

Any defiency statement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) I			(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILI	DING	00	COMPL	
		15G553	B. WING			03/05/	2012
NAME OF B	DOLUMEN ON GUINN HER		'	STREET A	DDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER	<u>.</u>		1921 54	TH AVE W		
	NORTHWEST INDI			MERRIL	LVILLE, IN 46410		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL	P	REFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	ГЕ	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	ļ	TAG	DEFICIENCY)		DATE
W0125	483.420(a)(3) PROTECTION Control of the facility must clients. Therefore encourage individuals as clients of the United State complaints, and a Based on observation interview, for 1 control of the facility of the group that the conducted at the office on 2/27/12 of the group home 2/27/12 indicated legally sanctione assist in medical A morning observation period oxygen mask. Communicate durobservation period observation period observation period observation period oxygen mask. Communicate durobservation period oxygen mask.	or CLIENTS RIGHTS ensure the rights of all re, the facility must allow and dual clients to exercise their of the facility, and as citizens stes, including the right to file the right to due process. ation, record review and of 2 sampled clients acility failed to ensure the not obtaining a health we or legally sanctioned o assist in medical and ass. : facility's record was facility's administrative at 10:00 A.M Review are client roster dated d client #1 did not have and decision maker to and financial decisions. vation was conducted at the 2/27/12 from 6:00 A.M During the entire and client #1 wore an lient #1 did not tring the entire	W012	25	An application for guardianship has been submitted. NIAGS is pursuing Guardianship through the Indiana Courts. To ensure future compliance the Service Coordinator will maintate contact with NIAGS weekly to monitor the status/progress.	s n	04/04/2012
		· · · · · · · · · · · · · · ·					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: G2Y011

Facility ID: 001067

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	OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED	
AND PLAN	OF CORRECTION	15G553		LDING	00	03/05/	
		100000	B. WIN			03/05/	ZU 1Z
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
ARC OF	NORTHWEST INDI	ANA INC, THE			ITH AVE W LLVILLE, IN 46410		
(X4) ID	SUMMARY S	FATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	, The state of the	CY MUST BE PERCEDED BY FULL	PREFIX (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO		ATE	COMPLETION	
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		facility's administrative					
		2 at 12:15 P.M Review					
		onference Summary					
	Form" dated 1/18						
		d assistance in making					
	"	ons. Encourage her to					
	_	lecision making skills by					
		unities to make single					
	decisions/choices	s." The "Developmental					
	Assessment" date	ed 3/14/11 indicated:					
	"Cannot read or	write, has no					
	understanding of	numbers. Needs					
	assistance in mor	ney handling, banking,					
	budgeting, shopp	oing and purchasing.					
	Does shopping w	ith close supervision.					
	Unable to endors	e a check." The					
	Individual Suppo	ort Plan (ISP) dated					
	1/18/12 indicated	d: "Legal Status:					
	SelfIndividual's	s Diagnosis: Diabetes,					
	History of Bowe	l obstruction, Gastro					
	RefluxEmerger	ncy Contact: None					
	notedWill cont	inue to learn to sort coins					
	into bowls by am	nount (Pennies, Nickels,					
	Dimes and Quart	ters)Will continue to					
	learn the name ar	nd purpose of one of her					
	medicationsNo	n-insulin dependent					
	Diabetes Mellitu	s-controlled by					
	medication, Histo	ory of seizures, History					
	of bowel obstruc	tions-High Risk plan,					
	GERD (gastro-es	sophageal reflux disease)					
		dication and risk plan,					
		c appliances on both					
	_	a/COPD (chronic					
		onary disease)-High risk					
	<u> </u>	<u> </u>					

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Event ID: G2Y011

Facility ID: 001067

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE C		(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		15G553	B. WING		03/05/2012
NAME OF F	PROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP CODE	
				SATH AVE W	
	NORTHWEST IND		MERR	ILLVILLE, IN 46410	
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIENCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	
TAG		LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCI)	DATE
	1	idism and Hypertension			
		ation in respiratory status			
		a/COPD, BiBap (bilevel			
	1 * * * * * * * * * * * * * * * * * * *	oressure), on oxygen			
		eview of client #1's			
		ctors Assessment" dated			
		d: "Has or has had			
		roblems /illnesseshas			
		lth problem/illness in			
	past 12 months				
	' - '	n) visit, admission to			
	1	r infirmary for treatment			
		nic health problem in past			
		ently taking one or more			
	prescription med	licationsdiagnosis of GI			
	(gastro intestinal) Reflux or receives			
	treatment for GE	ERD symptomsis			
	unaware of envir	ronmental			
	dangersalterati	on in respiratory status			
	related to asthma	with COPD, non-insulin			
	dependent diabet	tes mellitus at risk for			
	hyper or hypo gl	ycemic reaction, GERD,			
	Hypothyroidism	, hypertension and bowel			
	obstruction, rela	ated to hypothyroidism,			
	continuous oxyg	en."			
	An interview wit	th the Service			
	Coordinator (SC) was conducted at the			
	facility's adminis	strative office on 2/29/12			
	1	C #1 indicated client #1			
		ally sanctioned decision			
		n making medical and			
		ns and was not capable of			
		and financial decisions			

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	TOF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA OF CORRECTION IDENTIFICATION NUMBER: 15G553	(X2) MULTIPLE CO A. BUILDING B. WING	00		TE SURVEY MPLETED 05/2012	
	PROVIDER OR SUPPLIER NORTHWEST INDIANA INC, THE	STREET ADDRESS, CITY, STATE, ZIP CODE 1921 54TH AVE W MERRILLVILLE, IN 46410				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
	independently.					
	9-3-2(a)					

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Facility ID: 001067

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CC	ONSTRUCTION	(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A BUI	LDING	00	COMPL	ETED
		15G553	B. WIN			03/05/	2012
NAME OF I				STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIER			1921 54	4TH AVE W		
ARC OF	NORTHWEST INDI	IANA INC, THE		MERRI	LLVILLE, IN 46410		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	,	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	_	TAG	DEFICIENCY)		DATE
W0249	formulated a clie each client must treatment progra interventions and number and freq achievement of tindividual progra Based on observinterview, the fact sampled clients a (clients #1, #2, #	nterdisciplinary team has int's individual program plan, receive a continuous active in consisting of needed diservices in sufficient uency to support the che objectives identified in the implan. ation, record review and cility failed 2 of 2 and 2 additional clients 3 and #4) to implement is during times of training	W0	249	Service Coordinator will re-train DSPs on implementation of programming for clients # 1,2, &4 To ensure future compliance, Service Coordinator will monitor twice monthly for 3 months an monthly thereafter.	3 or	04/04/2012
	the group home of A.M. until 8:45 A observation period #4 sat in the living activity. At 7:20 Professional (DS #3's medications client #3's medications client #3's medications. Client medications. Client medications. Client #2 paper towel and	evation was conducted at on 2/27/12 from 6:00 AM. During the entire od clients #1, #2, #3 and any room area with no A.M., Direct Support SP) #1 administered client. DSP #1 popped each of ations onto a paper towel itent #3 to take her itent #3 was not asked to be to tropical medications. At #1 administered client. DSP #1 popped out its medications onto a instructed client #2 to itons. Client #2 did not					

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				NSTRUCTION 00	(X3) DATE (COMPL		
		15G553		LDING		03/05/	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER				TH AVE W		
ARC OF	NORTHWEST IND	IANA INC, THE		MERRIL	LVILLE, IN 46410		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL	PREFIX (EACH CORRECTIVE ACTION SHOULD F CROSS-REFERENCED TO THE APPROP DEFICIENCY)		TE	COMPLETION	
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCE		DATE
	ailments. At 7:5	d symptoms of her					
		ent #1's medications.					
		each of client #1's					
		client #1's hands and					
	instructed client						
		ient #1 was not prompted					
		and purpose of her					
	medications. Du	ring the observation					
	Direct Care Staff	f (DCS) #2 prepared					
	oatmeal and toas	t. While DCS #1					
		rning meal clients #1, #2,					
		the living room with no					
	1	ction. At 8:10 A.M.,					
		around the table, set each					
		plate and served each					
		fast onto their plates and					
	bowls.						
	Client #1's record	ds were reviewed on					
	2/29/12 at 12:15	P.M A review of the					
	client's Individua	al Support Plan (ISP)					
	dated 1/18/12 inc	dicated: "Will continue					
	to learn to sort co	oins into bowls by					
	`	, nickels, dimes and					
		earn to engage in a group					
		dailywill learn to make					
		continue to learn the					
	name and purpos						
		ll complete a personal					
	skills checklist."						
	Client #2's recor.	ds were reviewed on					
		A.M A review of the					
	2,27,12 at 11.30	71.111 11 10 110 W OI till					

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Facility ID: 001067

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G553		ULTIPLE CO LDING	NSTRUCTION 00	(X3) DATE COMPI 03/05	ETED
		100000	B. WIN			03/05/	2012
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
ARC OF	NORTHWEST INDI	ANA INC, THE			TH AVE W LLVILLE, IN 46410		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTIO		(X5)
PREFIX	``	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROP DEFICIENCY)		COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		1 12/8/11 indicated:					
	"Will learn to set	•					
		nue to learn about her					
	inedications, sign	ns and symptoms."					
	Client #3's recor	ds were reviewed on					
		A.M A review of the					
		1 1/19/12 indicated:					
		hoice of two items, will					
	_	ng to the one she wants					
		with otherswill match					
		coinswill learn to set					
		table when given initial					
	-	continue to respond					
	correctly to oral	•					
	<u>-</u>	complete a daily hygiene					
		ontinue to work on					
	sensory activities	swill continue to					
	engage in a grou	p socialization activity."					
	Client #4's record	ds were reviewed on					
	2/29/12 at 12:35	P.M A review of the					
	client's ISP dated	1 1/23/12 indicated:					
		ok a healthy side					
	dishwill read to	other clientswill					
		e change for up to					
		nue to learn to cook a					
	-	will continue to learn					
		ationwill continue her					
	Physical Therapy						
	_	hygiene checklist					
	including flossin	g her teeth."					
	The Service Coo	rdinator (SC) was					

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	NT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA I OF CORRECTION IDENTIFICATION NUMBER: 15G553	(X2) MULTIPLE CC A. BUILDING B. WING	00	— COM	TE SURVEY MPLETED 05/2012	
	PROVIDER OR SUPPLIER NORTHWEST INDIANA INC, THE	STREET ADDRESS, CITY, STATE, ZIP CODE 1921 54TH AVE W MERRILLVILLE, IN 46410				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION : CROSS-REFERENCEO TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
	interviewed on 2/29/12 at 12:40 P.M The SC indicated active treatment should be ongoing and training objectives should be implemented at all times of opportunity. 9-3-4(a)					

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DA7			(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPLI	ETED
		15G553	B. WIN			03/05/	2012
					ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER				4TH AVE W		
ARC OF	NORTHWEST INDI	ANA INC, THE			LLVILLE, IN 46410		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	, The state of the	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
W0388	based on current principles and pr	G gs and biologicals must be tly accepted professional ractices.	W0388		Community Services Nurse wi	11	04/04/2012
		ation, record review, and	****	300	check all medications for prop		04/04/2012
		cility failed for 1 of 4			Labeling		
	clients (client #3)						
	·	ave the medication			To ensure future compliance,		
	labeled from the	pharmacy.			Community Services Nurse wi		
	Findings include	:		review new medication monthly &/or as orde		• • •	
	A morning obser	vation was conducted at					
	_	on 2/27/12 from 6:00					
	• 1	A.M Client #3's					
		e administered by Direct					
		onal (DSP) #1 at 7:20					
	A.M A medica	•					
		ium tablet was taken					
	from client #3's u	unlabeled medication					
	bag. The packet	did not contain client					
	#3's name or inst	ructions for					
	administration.	The packet did not					
	contain a pharma	-					
	•						
		s conducted on 2/27/12 at					
	7:23 A.M., with						
	indicated the pac	ket was for client #3,					
	however it did no	ot have a pharmacy label					
	on it.						
	A review of clier	nt #3's record was					
	conducted on 2/2	29/12 at 11:15 A.M					
	Client #3's Febru	ary 2012, Physicians					

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				NSTRUCTION 00	(X3) DATE COMPL		
		15G553	A. BUII B. WIN	LDING G		03/05/	
NAME OF P	DOWNED OF CURRITIES	<u> </u>	S. 1711		DDRESS, CITY, STATE, ZIP CODE		
	PROVIDER OR SUPPLIER				TH AVE W		
	NORTHWEST IND			MERRIL	LLVILLE, IN 46410		
(X4) ID PREFIX	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL			ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	ION (X5) D BE COMPLETION	
TAG		LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
	Orders (PO) indi	cated: "Alendronate					
	Sodium tablet7	70 mg. (milligram) once					
	weekly."						
		~ .					
	An interview wit						
	,) was conducted on P.M The SC indicated					
		hould have a pharmacy					
	label on them.	nouse nuve a pharmacy					
	9-3-6(a)						

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STATEMEN	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE SU			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DIJII DING	00	COMPLETED	
		15G553	A. BUILDING B. WING		03/05/2012	
			_	ET ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIE	R				
ADC OF	NORTHWEST IND	JANA INC. THE		54TH AVE W RILLVILLE, IN 46410		
			IVILIN			
(X4) ID		STATEMENT OF DEFICIENCIES	ID PROVIDER'S PLAN OF CORRECT		(X5)	
PREFIX	`	NCY MUST BE PERCEDED BY FULL	PREFIX	CROSS-REFERENCED TO THE APPROPR	IATE COM EETION	
TAG		R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE	
W0484	483.480(d)(3)					
		AND SERVICE				
		t equip areas with tables, ensils, and dishes designed				
		elopmental needs of each				
	client.	ciopmental needs of each				
		vation and interview, the	W0484	Service Coordinator will re-tr	ain 04/04/2012	
			1,0101	DSPs on providing condimer		
	1	r 4 of 4 clients (clients #1,		the table during all meal time	I	
		iving in the group home to				
	provide condime	ents at the dining table.		To ensure future compliance	•	
				Service Coordinator will mon		
	Findings include	e:		twice monthly for 3 months, a	and	
	_			monthly thereafter		
	A morning obse	rvation was conducted at				
	_	on 2/27/12 from 6:00				
		A.M During the				
		•				
		ect Support Professional				
		red oatmeal and toast. At				
	8:10 A.M., clien	its #1, #2, #3 and #4 were				
	observed eating	breakfast. The table was				
	observed to have	e no butter, jelly,				
	sugar/sugar subs	stitute or milk. DSP #2				
	-	ny condiments for the				
	clients to use.	any condimions for the				
	chemis to use.					
		4.4.0				
	An interview wi					
	`	c) was conducted on				
	2/29/12 at 12:40	P.M The SC indicated				
	condiments shou	ald be put on the table for				
	the clients to use	e at all meals.				
	9-3-8(a)					
	()					

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/23/2012 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G553		A. BUILDING B. WING		COMPLETED 03/05/2012		
	ROVIDER OR SUPPLIEF		1921 54	ADDRESS, CITY, STATE, ZIP CO ITH AVE W LLVILLE, IN 46410)DE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AF DEFICIENCY)	OULD BE	(X5) COMPLETION DATE

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STATEMENT OF DEFICIENCIES X		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING 00		00	COMPLETED	
	15G553		A. BUILDING B. WING			03/05/2012	
			D. WIIV		ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
NAME OF P	ROVIDER OR SUPPLIER	2			TH AVE W		
ARC OF NORTHWEST INDIANA INC, THE			MERRILLVILLE, IN 46410				
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID PROVIDER'S PLAN OF CORRE		PROVIDER'S PLAN OF CORRECTION	ON (X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL	PREFIX		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG DEFICIENCY)			DATE
TAG W0488	483.480(d)(4) DINING AREAS The facility must in a manner considevelopmental le Based on observation developmental le Based on observation developmental le Based on observation developmental le A sampled clients #1 participated in fa Findings include A morning observation developmental le Findings include A morning observation developmental le A.M. until 8:45 A observation Dire prepared oatmea #1 prepared the r #2, #3 and #4 sat no activity. At 8 walked around th bowl and plate at their breakfast on bowls. Clients #1 assist in meal preserve themselves Client #1's record 2/29/12 at 12:15 client's 12/27/10 Functional Asses client was developmental le Based on observation developmental le Based on observation at manner factories Client #1's record 2/29/12 at 12:15 client's 12/27/10 Functional Asses client was developmental le Based on observation at manner factories A morning observation factories A morning observation factories A morning observation factories Client #1 prepared the r #2, #3 and #4 sat no activity. At 8 walked around the bowl and plate and their breakfast on bowls. Clients #1 assist in meal preserve themselves Client #1's record 2/29/12 at 12:15 client's 12/27/10 Functional Asses client was developmental le Based on observation and servation developmental le Based on observation and servation developmental le Based on observation and servation developmental le Based on observation and servation developmental le Based on observation	AND SERVICE assure that each client eats sistent with his or her evel. ation, record review, and cility failed to assure 4 of s living in the group , #2, #3, and #4) amily style dining. Treation was conducted at on 2/27/12 from 6:00 A.M During the ext Care Staff (DCS) #2 I and toast. While DCS morning meal clients #1, t in the living room with 8:10 A.M., DCS #2 the table, set each client's and served each client each client into their plates and #1, #2, #3 and #4 did not exparation and did not separation and did not sessment indicated the commentally capable of	Wo		Service Coordinator will re-train DSPs to encourage all clients participate in meal preparation and serving themselves to the extent of their capabilities. To ensure future compliance, Service Coordinator will monitor twice monthly for 3 months, the monthly thereafter.	to ı, or	04/04/2012
	bowls. Clients # assist in meal preserve themselves Client #1's record 2/29/12 at 12:15 client's 12/27/10 Functional Asses	ds were reviewed on P.M A review of the Comprehensive ssment indicated the					

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	AND PLAN OF CORRECTION X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G553		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 03/05/2012		
NAME OF PROVIDER OR SUPPLIER ARC OF NORTHWEST INDIANA INC, THE			STREET ADDRESS, CITY, STATE, ZIP CODE 1921 54TH AVE W MERRILLVILLE, IN 46410					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		(X5) COMPLETION DATE	
	2/29/12 at 11:30 client's 11/21/11 Functional Asses client was developarticipating in decient #3's record 2/29/12 at 10:40 client's 1/19/12 I (ISP) indicated the developmentally in dining and me Client #4's record 2/29/12 at 12:35 client's 1/23/12 I to cook a healthy An interview with Coordinator (SC 2/29/12 at 12:40 clients #1, #2, #3	ds were reviewed on A.M A review of the ndividual Support Plan he client was capable of participating al tasks. ds were reviewed on A.M A review of the ndividual Support Plan he client was capable of participating al tasks. ds were reviewed on P.M A review of the SP indicated: "Will learn a side dish." the the Service was conducted on P.M The SC indicated and #4 were capable of participating						

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